

PERTUSSIS – MANAGEMENT OF PATIENTS AND EXPOSED STAFF - CHW POLICY®

DOCUMENT SUMMARY/KEY POINTS

- All children with a provisional diagnosis of Pertussis are nursed in **droplet isolation** on any ward.
- **Neonates:** Emergency Department should check NICU and PICU bed availability.
- The following management principles are **mandatory for each patient:**
 - The child is nursed using Droplet Precautions for the 5 days after the commencement of antibiotics.
 - A self –inflating resuscitation bag and mask is kept by the bedside at all times.
 - Continuous cardiorespiratory monitoring and pulse oximetry at all times.
 - 4L of oxygen via an oxygen face mask must be available by the bedside at all times
 - If the child has an apnoea, he/she is to be hand ventilated with a self-inflating resuscitation bag and mask in 100% oxygen. If there is no immediate response, initiate a rapid response or arrest call (dial **444**) as per normal resuscitation training.
- Regarding **staff members:**
 - NSW Health policy states staff members who are not up-to-date with vaccination cannot work in NSW Health facilities¹³.
 - A vaccine is available for booster vaccination of individuals such as adults who have previously had a primary course³. Contact Work Health Safety & Injury Management Department (ext 53646).
 - All pertussis-exposed staff members should be counselled by Infection Control team or Work Health Safety & Injury Management Department regarding the incubation period and early symptoms of infection.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1 st March 2015	Review Period: 3 years
Team Leader:	Clinical Nurse Consultant	Area/Dept: Infection Control

CHANGE SUMMARY

- Due for mandatory review: minor changes only to update links.

READ ACKNOWLEDGEMENT

- Medical and Nursing staff working in clinical areas are required to read and acknowledge the document.
- All other staff should be aware of this document, particularly if they have been exposed to pertussis.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

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Introduction

“Pertussis, or whooping cough, is an acute infection of the respiratory tract caused by *Bordetella pertussis* and less frequently by *B. parapertussis*. Whooping cough caused by *B. pertussis* is preventable with vaccines”².

The Pertussis bacteria attach themselves to the cilia (little hairs) that line the respiratory tract. These bacteria produce a potent toxin that inflames the respiratory tract and prevents the cilia from functioning properly¹².

Clinical Features of Pertussis

- Pertussis begins as a mild illness known as the “catarrhal phase” when the patient’s symptoms are indistinguishable from those of a common cold.
- This is typically followed by the paroxysmal phase characterised by paroxysm of cough often followed by an inspiratory whoop and/or vomiting, although this may be atypical in adults⁵.
- Young infants may have apnoea alone, and are at risk of serious complications and even death from pertussis.
- For very young babies, Pertussis is a dangerous illness and they can die from pneumonia, respiratory failure, seizures and encephalopathy.
- The whoop may be absent in young infants or immunised older children or adults^{3, 5}.
- Adults rarely develop life threatening complications of pertussis but they may have a very troublesome prolonged cough. (Pertussis is called the “100 day cough” in China).
- Importantly, the symptoms in adults are often atypical, and therefore less likely to be recognised clinically.
- In the healthcare setting, infected staff may transmit pertussis to vulnerable patients as well as to other staff members⁴.
- Older children are more likely to be admitted for management of cough induced vomiting and dehydration.

Command and Control – Staff Responsibilities

- The management of affected patients is the responsibility of the clinical teams and the ward nursing staff
- The management of exposed staff is the responsibility of their line managers.
- The Infection Control staff and the Infectious Diseases team are available to advise the teams and managers on aspects of Infection control and cross infection.

- Isolation of pertussis identified by the clinical manager or the Infectious Diseases team must be reported to Infection Control who will determine the type and level of response and provide advice on implementation of this policy.
 - Pertussis is a notifiable disease and **must be reported** to Public Health Units (PHU) as per Hospital and NSW Health policy:
<http://www.health.nsw.gov.au/factsheets/guideline/pertusis.html>
 - A Reportable Incident Brief (RIB) must be sent to the NSW Health for any potential media interests or problems. This decision and responsibility lies with the Chief Executive.
 - The Infectious Diseases team or Infection Control Practitioner will notify the Director of Clinical Operations of the identification of any clusters of hospital acquired of pertussis. The Director of Clinical Operations will in turn notify the Chief Executive.
 -
- A report on the management of any clusters of hospital acquired Pertussis will be made to the next Infection Control Committee meeting.

Clinical Patient Care

The clinical management of Pertussis cases is primarily supportive. Supportive measures with hydration and oxygenation may be necessary.

Isolation

- Children with Pertussis or suspected Pertussis are to be nursed in an isolation room on any ward which has the ability to provide droplet isolation, thus alleviating the risk of cross-infection to other hospitalised children.
- Five (5) days after the commencement of antibiotic therapy (usually an antibiotic such as erythromycin, clarithromycin, azithromycin or cotrimoxazole), the child is considered to be no longer infectious and droplet precautions are no longer necessary. They may be nursed elsewhere within the Hospital.
- Neonates with Pertussis or suspected Pertussis are to be nursed in Grace Centre for Newborn Care or Paediatric Intensive Care in designated isolation beds (if available). Staff are to check for bed availability in these areas as per normal protocols.

Nursing

- The child should be nursed in a lateral position, not prone, with the head of the cot slightly elevated.
- Whilst coughing, position the infant in an upright position supporting the chin and head. For older children, encourage them to sit up when coughing.
- Ensure adequate lighting above the child's cot/bed at all times.

Oxygen

- Oxygen running at a minimum of 4L/min via an oxygen face mask must be readily available and within reach at all times.
- Administration of oxygen at a minimum of 4L/min via an oxygen face mask must be used when the infant or child is:
 - pale
 - dusky
 - cyanosed
 - bradycardic (**N.B:** Bradycardia is an emergency if the patient does not respond immediately to oxygen and requires bagging using a self-inflating resuscitation bag)
 - oxygen saturation is <93%

Maintenance of Hydration and Nutritional Status

- Smaller, frequent feeds are more easily tolerated.
- Monitor the infant/child for signs of poor oral intake.

Observations

- The child **must be observed closely**; depending upon the location of the child in the Hospital *includes* continuous cardio-respiratory and pulse oximetry monitoring. (Hypoxia can be associated with the coughing spells and resulting bradycardia).
- Record all coughs lasting longer than 10 seconds on the Observation Chart MR 36c, the following headings are required:
 - date
 - time
 - duration (of cough)
 - colour/SpO₂ (oxygen saturation taken from Pulse Oximeter)
 - comments, e.g. whoop heard, O₂ required, etc
 - signature of the nurse witnessing the coughing episode
- Record all condition changes in the medical record

Resuscitation measures

- All staff must wear a surgical mask
- An appropriate sized self-inflating resuscitation bag and mask is to be kept connected to an oxygen outlet when frequent cyanotic or apnoeic episodes are evident. (**NB:** Resuscitation equipment must not be removed from the Emergency trolley but procured from the Inhalation Therapy/Biomedical Department).
- **Suction is contraindicated** for patients with Pertussis, except in an emergency situation, as this may cause a severe paroxysm secondary to vagal stimulation¹. A tissue may be used to wipe the secretions from the child's mouth.

- Bagging with a self-inflating resuscitation bag and mask can cause coughing spasms if it is done unnecessarily. Desaturation when the baby is breathing spontaneously (albeit with tachypnoea and respiratory distress) needs oxygen and not bagging.

Apnoea Management

- The child/infant is to be hand ventilated with a self-inflating resuscitation bag and mask in 100% oxygen if apnoeic. If no immediate response, the nurse should call for assistance using the bedside emergency bell as per normal resuscitation training and assistance will come and initiate a rapid response or arrest call [dial extension **444** from the nearest telephone].
- Apnoea is very common in Pertussis. **Note: every apnoea must be treated as an emergency.**
- An emergency is described as being:
 - Any bradycardia or any coughing spasm that causes desaturation to SpO₂ <90%
 - Cyanosis/duskiness/severe pallor if saturation probe is not working
 - Any apnoea >15 seconds in an infant or >10secs in a toddler
 - Any apnoea of any duration that causes desaturation/cyanosis as above
 - Any other progressive respiratory failure leading to severe respiratory distress or SpO₂ <90%
 - Depressed level of consciousness

Maintenance of Parental Involvement and Education

- Facilitate parental involvement in managing the coughing episodes and all general care the child/infant requires.
- Parental education is paramount, advice on coping with the coughing at home and the benefits of a smoke free environment should be included.

Parent Fact Sheet

- Refer to: <http://www.schn.health.nsw.gov.au/parents-and-carers/fact-sheets/whooping-cough>

Nasopharyngeal aspirates for diagnosis

- Nasopharyngeal aspirates (NPA's) may be taken by nursing staff, having first ensured a senior medical officer skilled in resuscitation (e.g. Medical Registrar) is present within the ward area at the time of collection. The reason being that if the suctioning causes a severe paroxysm, the child may need resuscitation.
- Collect the NPA as per CHW NPA Procedure:
<http://chw.schn.health.nsw.gov.au/o/documents/policies/procedures/2006-8061.pdf>
- NPAs are sent to pathology with an order form testing for Pertussis culture and PCR.
Note: NPAs for Pertussis culture are *NOT* to be put on ice. Transfer the specimen to Pathology without delay.

Cleaning of equipment and room after use

- Routine cleaning is required. No special cleaning is required.

Infection Control Precautions

- The **Infection Control Team should be contacted** to advise and assist with the implementation of the Infection Control precautions.
- **Adherence to precautions is our best defence against the transmission of pertussis.**
- Standard Precautions **must** be maintained at all times, whether or not the patient has confirmed pertussis.
- In addition to standard precautions, **Droplet Precautions must be commenced immediately** following the notification of a probable or confirmed pertussis.

Droplet Precautions

(Refer to [Infection Control: Isolation Practice Guideline](#) for Droplet Precaution details)

- Droplet Precautions are designed to reduce the risk of droplet transmission of infectious agents.
- Droplet Precautions **apply to all persons entering the room** (Medical staff, Nurses, Physiotherapists, Pathology collectors, patient relatives and visitors, etc).
- Wear protective eyewear and a surgical mask when **attending the child, during intubation, suction and during the collection of NPA's.**
- **Before and after** patient contact: Handwash with 2% Chlorhexidine solution **or** use alcohol handrub. *Allow alcohol to dry.*

Additional precautions

- Parents should be discouraged from allowing siblings or other family and friends to visit if they are not fully immunised or not receiving prophylactic antibiotic therapy.
- Medical teams caring for children in the same ward area as a patient with infectious Pertussis should consider prescribing prophylactic antibiotics to these children. This decision needs to be individualised based on proximity to the index case, duration of exposure, age, immunisation status, co-morbidities, and contraindications to antibiotic use. This can be discussed with a member of the Infectious Disease or Clinical Microbiology team. NSW Health policy¹¹ states *a high probability of infection may be assumed for an infant spending an hour in the same room as an infectious case, or directly exposed to their respiratory secretions while coughing.*

It is the responsibility of the ward unit manager to ensure that medical teams caring for these children are alerted to the possible exposure.

- Parents and medical staff caring for exposed children who do not receive prophylactic antibiotics should be alerted to the possibility of illness beginning 6-21 days post-

exposure.

Early *diagnostic* testing (PCR &/or culture) is advised if such an illness occurs.

Staff Vaccination

- NSW Health mandate staff members who are not up-to-date with vaccination are not allowed to work in NSW Health facilities¹³.
- An a-cellular Pertussis vaccine is available for booster vaccination of individuals such as adults who have previously had a primary course³. It is not recommended for adults whose primary immunisation course was incomplete³.
- All enquiries, contact Work Health Safety & Injury Management (WHS&IM) Department on extension 53646.

Management of occupationally exposed staff

Assessment of exposure

- Transmission of Pertussis is by respiratory droplets from the upper airway of an infected host.
- The most contagious period of infection is the initial catarrhal phase, which is usually indistinguishable from a common cold.
- Infectivity persists for up to 3 weeks following the onset of cough or up to 5 days after initiation of effective antibiotic therapy⁵.
- We do not fully understand what degree of workplace contact with a person suffering from Pertussis is required for staff infection to occur.
- NSW Health policy¹¹ states that direct contact with respiratory secretions is generally considered “significant contact”. People within 1 metre of an infectious case are at highest risk. Other high risk activities include mouth to mouth resuscitation and examination of the nose, mouth or throat.
- Staff who have spent a total of 1 hour within 1 metre of an infectious case will usually be offered prophylactic antibiotics, unless medical contraindications exist. However staff with shorter periods of close contact may also be considered for antibiotic prophylaxis, particularly if they will have ongoing extensive contact with neonates.
- Suitable antibiotics for post-exposure antibiotic prophylaxis include erythromycin⁶, clarithromycin, azithromycin, or cotrimoxazole^{7, 11}.
- Pertussis-exposed women in the last month of pregnancy should consider taking prophylactic antibiotics even if they do not fall into one of the above categories since pertussis in a neonate may be life-threatening. Expert advice should be sought regarding this decision, and the most appropriate prophylactic agent.

Assessment of susceptibility

- Susceptibility to Pertussis is universal.
- Natural infection confers long-lasting but not permanent immunity.
- Staff members who have received an adult booster within 5 years are also expected to have approximately 80 - 85% protection, infection may occasionally occur despite up-to-date vaccination.
- The duration of protection after an adult booster is currently unknown, and there are no recommendations regarding re-immunisation following an adult booster due to a lack of safety data³.

Identification and management of staff contacts

- It is the responsibility of the ward or unit manager, in consultation with Infection Control, to identify and appropriately refer all staff contacts of an identified infectious Pertussis case.
- All staff who have had a full primary (childhood) vaccination course and come into any direct contact with an infectious case of should be offered an adult dTPA booster, unless they have had one previously or there are genuine contraindications to the vaccine³. Contact WHS&IM Department (ext 53646) or organise with your GP. Staff who have had significant contact (as defined by duration, proximity and type of contact above) with an infectious person should be offered antibiotic prophylaxis unless there is a medical contraindication.
- Staff, with lesser degrees of contact may be offered antibiotic prophylaxis on a case-by-case basis, particularly if they have not received a Pertussis booster in the last 5 years. Particular staff who should be referred urgently for consideration of antibiotic prophylaxis include women in their last month of pregnancy, and staff who will have ongoing extensive contact with neonates.
- The staff member's regular medical practitioner should be the first point of contact regarding antibiotic prophylaxis. A form letter for staff to take to their general practitioner is attached as an appendix to this document.

Exclusion of significant staff contacts

- Staff who have had significant contact (as defined above) or on antibiotic prophylaxis following shorter periods of close contact with an infectious person should be excluded from work from 5 days after their first potential exposure, until 14 days after their last potential exposure or until they have completed 5 days of appropriate antibiotic prophylaxis^{9, 10}.
- It is the responsibility of the ward or unit manager, in consultation with Infection Control, to identify significant staff contacts of an identified infectious Pertussis case, and to implement the exclusion provisions.
- Staff who have had contact with an infectious case of Pertussis and develop a cough or runny nose between 6 and 21 days after exposure should seek medical attention before attending work.

- Unless Pertussis can be confidently excluded on clinical grounds, Pertussis culture and/or PCR should be performed on a posterior nasal swab and a throat swab (flocked swabs should be used if available. The two specimens may be combined for processing by the laboratory). Specimens may be collected by WHS&IM Department if convenient (ext 53646).
- If Pertussis is considered clinically likely, then appropriate antibiotics should be recommended (provided there are no contraindications) pending the results of laboratory testing. Staff in whom Pertussis cannot confidently be excluded on clinical grounds or by laboratory testing should be excluded from work until they have completed 5 days of appropriate antibiotics in accordance with the “exclusion” section above.
- The staff member should report the illness and the results of the medical assessment to their immediate supervisor, who, in consultation with Infection Control, will advise when they can return to patient care duties.
- If pertussis is confirmed, prophylaxis should be considered for neonates who have been directly cared for by the staff member, parents/primary carers exposed to the staff member, and exposed Health Care Workers who will care for neonates in the next 3 weeks

Investigation of staff with a prolonged coughing illness

- Any staff member who develops a prolonged coughing illness should seek medical advice either from their local medical officer or via staff health.
- Unless Pertussis can be confidently excluded on clinical grounds, Pertussis culture and/or PCR should be performed on a posterior nasal swab and a throat swab (flocked swabs should be used if available. The two specimens may be combined for processing by the laboratory). As per instructions on previous page.
- If pertussis is suspected, the staff member may require exclusion from the workplace until they have completed 5 days of an effective antibiotic, or their PCR or culture test returns negative. The decision to exclude a staff member from work should be made by their line manager in consultation with Infection Control and/or Clinical Microbiology
- If pertussis is confirmed, prophylaxis should be considered for neonates who have been directly cared for by the staff member, parents/primary carers exposed to the staff member, and exposed Health Care Workers who will care for neonates in the next 3 weeks.

Further Information:

- SCHN Injury Management and Return to Work Procedure:
<http://chw.schn.health.nsw.gov.au/o/documents/policies/procedures/2013-9047.pdf>

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Appendix 1 Letter to GP

(use hospital Letterhead)

Dear Doctor,

Your patient _____ (name) _____ has been exposed to Pertussis in the workplace. They have been asked to see you for consideration of antibiotic prophylaxis.

We do not fully understand what degree of workplace contact with a person suffering Pertussis is required for staff infection to occur. NSW Health Department policy states that direct contact with respiratory secretions is generally considered “significant contact”. People within 1 metre of an infectious case are at highest risk. Other high risk activities include mouth to mouth resuscitation and examination of the nose, mouth or throat. Staff who have spent a total of 1 hour within 1 metre of an infectious case are usually offered prophylactic antibiotics, unless medical contraindications exist. However staff with shorter periods of close contact may also be considered for antibiotic prophylaxis, particularly if they will have ongoing extensive contact with neonates, or if they have not had an adult booster vaccine (Boostrix).

Pertussis-exposed women in the last month of pregnancy should also consider taking prophylactic antibiotics even if they do not fall into one of the above categories since pertussis in a neonate may be life-threatening

Since adults do not usually suffer such severe illness as children infected with pertussis, antibiotic prophylaxis of adults may be regarded as being particularly for prevention of infection of their contacts (both in and outside the workplace) more than for their own health benefit.

The decision to give prophylaxis therefore depends on the person's degree and duration of contact with an infectious person, the person's own immunisation history and health status, concurrent medication use, their degree of contact with vulnerable children (both in and outside the workplace) and their personal preferences.

The pharmacy at CHW will dispense appropriate antibiotic prophylaxis, prescribed by a medical officer, free of charge to staff members. Alternatively, reimbursement of drug costs may be obtained via the OHS&R Co-ordinator on Extension 53556 or page 6238.

Antibiotic regimens for prophylaxis are the same as those described for treatment. Suitable choices include erythromycin, clarithromycin, azithromycin, or co-trimoxazole:

- Erythromycin 250 mg QID X 7 days

Oral erythromycin is often poorly tolerated by adults, and nausea is common. It is contraindicated if hypersensitive to any macrolide antibiotic, and in persons with severely impaired hepatic function. Several serious drug interactions are possible, in particular with cisapride and pimozide.

- Clarithromycin 500 mg BD X 7 days

Clarithromycin is often better tolerated than erythromycin. It is contraindicated if hypersensitive to any macrolide antibiotic. Several serious drug interactions are possible, in particular with astemizole, terfenadine, cisapride, or pimozide.

- Azithromycin 500 mg on day 1, then 250 mg daily on days 2 to 5

Azithromycin is contraindicated if hypersensitive to any macrolide antibiotic. It does not interact significantly with the hepatic cytochrome P450 system, so lacks many of the drug interactions seen with other macrolides. In patients on cyclosporin, its serum levels may be elevated. Absorption is impaired when administered simultaneously with antacids.

- Co-trimoxazole 160+800 mg (“Bactrim DS”) tabs i BD X 7 days

Co-trimoxazole is usually reserved for patients in whom macrolide antibiotics are contraindicated. It has rare but serious toxicities including Stevens-Johnson syndrome (toxic epidermal necrolysis) and blood dyscrasias. It is contraindicated in patients with known hypersensitivity to the drug or its components (trimethoprim or sulfonamide agents). Interactions with other drugs include digoxin, warfarin, phenytoin, cyclosporin, methotrexate, PABA, urinary acidifiers, oral anticoagulants, phenylbutazone, oxyphenbutazone, indomethacin, sulfinpyrazone or salicylates.

Thank you for discussing the pros and cons of antibiotic prophylaxis with your patient. If you need any further information please call The Children's Hospital at Westmead on 9845 0000 and ask to speak to the Infectious Diseases Physician or Clinical Microbiologist “on-call”.

If your patient does not receive antibiotic prophylaxis, and develops a cough or runny nose between 6 and 21 days after exposure, they should seek medical attention before attending work. Unless Pertussis can be confidently excluded on clinical grounds, we would suggest that Pertussis culture and/or PCR should be performed on a posterior nasal swab and a throat swab (seek advice from your own pathology provider regarding specimen collection and handling requirements). If you and your patient prefer, they can attend Occupational Health and Safety at the hospital to have these specimens collected. You would need to provide a request for the test, but can use the forms for your regular pathology provider for this purpose.

Yours sincerely,